OPEN ACCESS

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Agenda

- What is Open Access
- How do you implement Open Access
- Statistical Data
- Lessons Learned from the 16th MDG, Hurlburt Field, Fl

Open Access History

- Based on civilian model- article in journal of *Family Practice Management* "Same-*Day Appointments: Exploding the Access Paradigm"*
- *Dr. Thomas Siskron at Hill AFB championed the implementation trial run 16 Jan 2001*
- *Completed Retrospective review 16 Mar 01*

Open Access Overview

- Current way of doing business best be described as ***backlogging***
- Theory behind this system is that demand is so high there is no way to generate adequate supply sufficient to meet demand
- Solution for this has been to schedule into future appointments
- Equivalent to shopping with credit card—interest accrues with a higher cost at a later date

Old System Appointment Criteria

- 1) The acuity of the patient's problem
- 2) The availability of a corresponding appointment type.
- This creates 2 problems:
- 1) Nearly 100% appts consumed before date of their use
- 2) Difficult to match "predicted" demand with actual demand

This leads us to the new system with a shift in access paradigm

The main fear is opening the flood gates of demand. The old system did provide a damn to stem the demand

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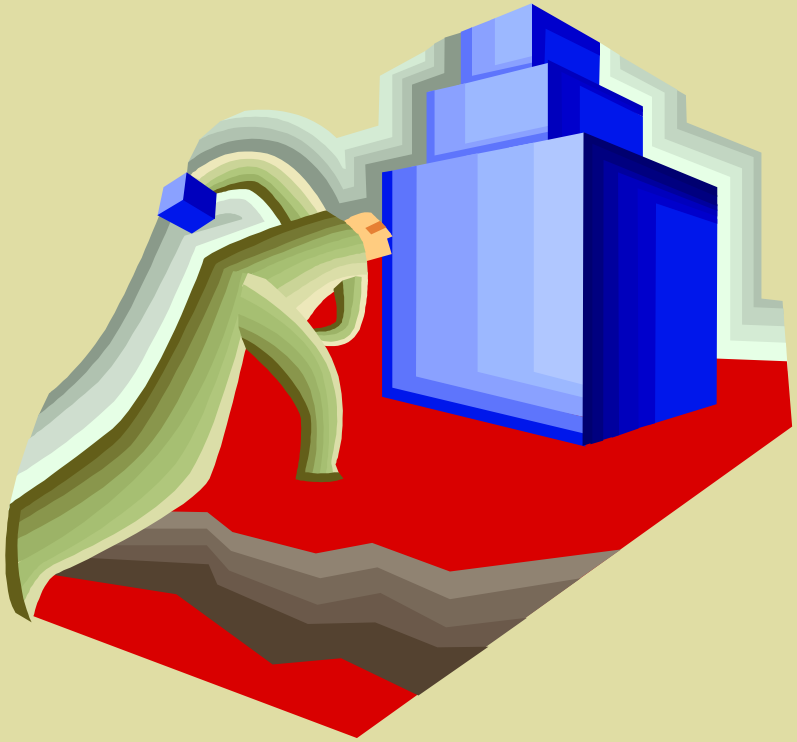


- The entire system has been developed based on a misconception:

The belief- Demand outweighs supply

Current studies- Indicate this is not the norm

<u>Demand is roughly = supply on day-to-day</u>

Open Access Daily Schedule

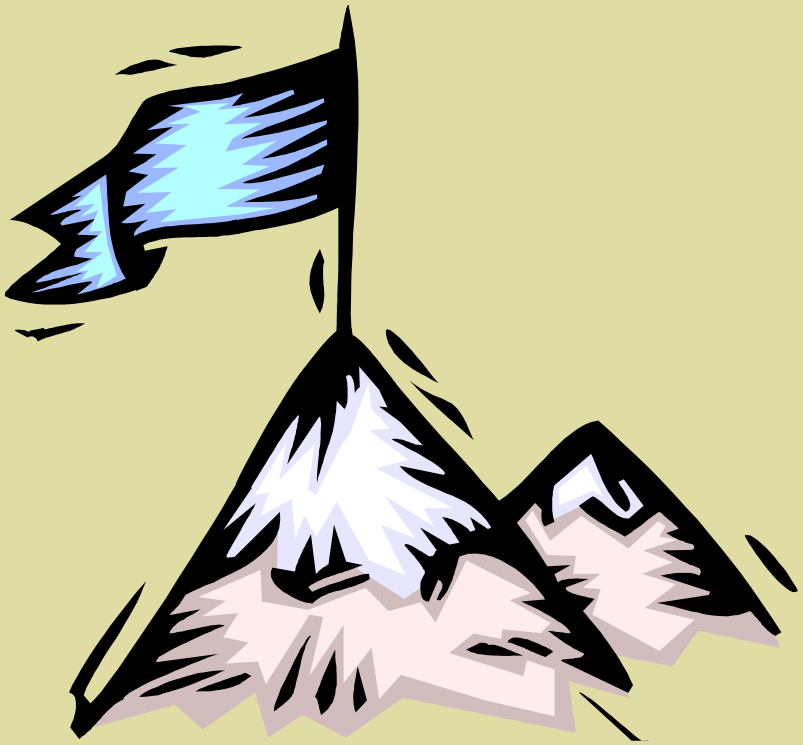
- 70 % daily schedule reserved for same-day use (to be called routine for booking)
- Remaining 30% “good backlog” to include: (to be called Established for booking in TriCare)
  - Patients who do not want to come in for same-day appt (SDA)-estimated 15-20% all who call
  - Provider requested follow-up appts
  - Patients who cannot be seen today due to lab or other test is still pending

Emphasis points

- No less than 4 providers at all times!! . The driving force for Open Access (or just meeting access standards in general) is to have providers in the clinic seeing patients so the supply will equal the demand
- Providers can use marketing of pts to utilize Saturday availability of appts
- Fill Appts *as early* in the day as possible
- Judiciously book EST appts with F/U appt
- Appts 15 min can link 2 appt to make 30 min
- Incorporated “wave concept of scheduling”

Implementation Date

- 1 Apr 02
  - Allows for schedules to clear up 30 days prior to implementation
  - Permit education and promotion of providers, staff and clients



Improvements in Backlog System

- Pts no longer pigeonholed into appt types- every appt is equal and available
- Providers begin each day with 70% open appts as of 0700. Last minute changes easier to accommodate

Under OA Two Criteria Used to Book Patients

- One, the time the patient calls
- Two, when the patient can make it to clinic
- No concern is given to the acuity of the patient (unless emergent) as it pertains to when they receive their appointment that day. ***GOAL*** every patient that calls today will be seen today…not always possible but at least every effort made if not today…in the future while the pt is still on phone. "*Do today's work today*"

Goals for Open Access

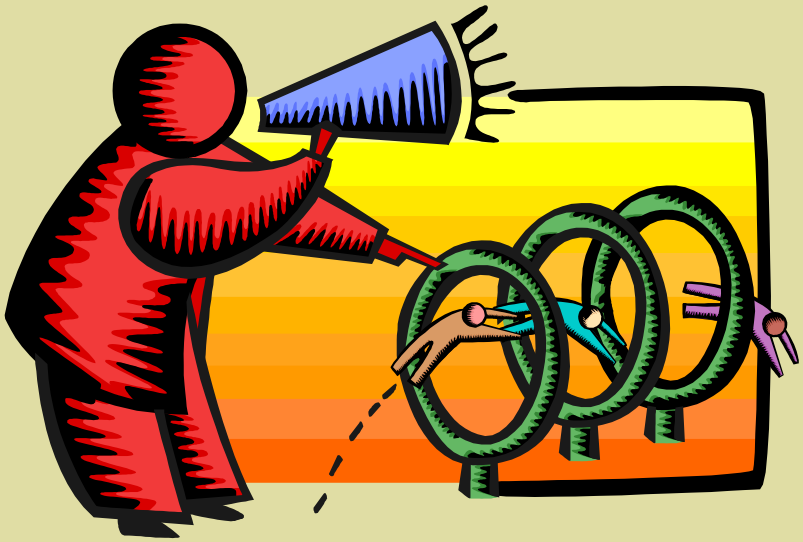
- Decrease wait time for pt access to PC appt
- Increase compliance with acuity standards defined by Access to Care (ATC) standards
- Increase the ability of pt to see their PCM
- Decrease number of pts who use care outside facility (recapture downtown pts)
- Decrease the number of pts who are forced to walk-in due to lack of appts

GOALS -continued

- Decrease the number of pts who cancel, NS, or LWBS
- Decrease the stress on clinic providers/staff
- Give more control over schedules
- Increase flexibility of the schedule to allow for provider absences and schedule changes
- Remember “Do today’s work today”

Determining Supply/Demand

- **Demand**: Estimated by # of pending events added to # of WI
- **Supply**: Best way to measure is by the actual # of appts seen by providers based on end-of-day accounting. Or estimated tot # kept/WI appts.* exclude supply from non-PCM



Caveats for OA success

- SUPPLY can only meet DEMAND if the providers are IN the clinic seeing patients
- Demand is usually decreased due to elimination of “artificial demand” (hence advertisers use “Hurry in, supply limited”)
- Keep in mind demand is on an average daily basis based on the actual # of duty-days in the month

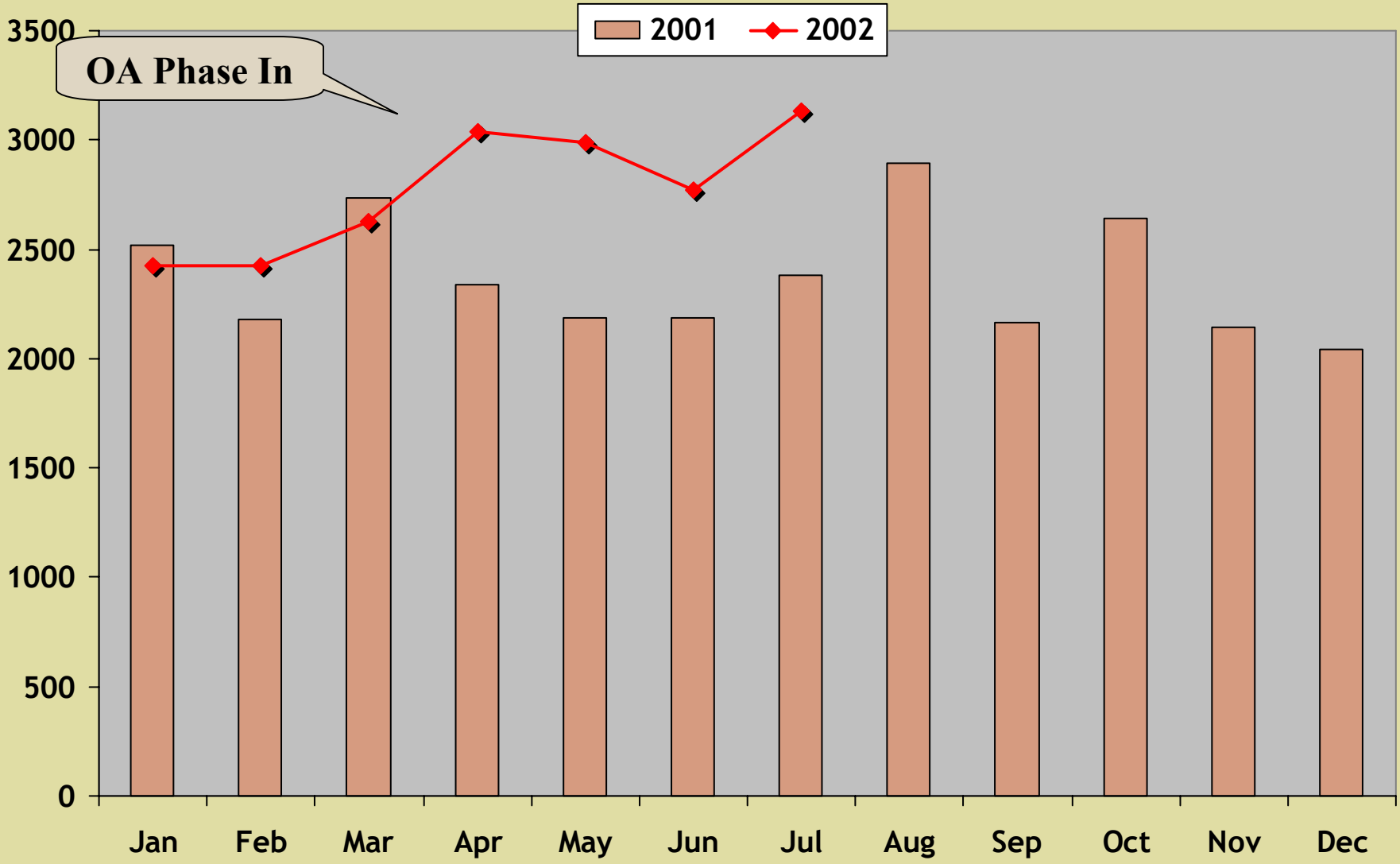
Assigning ATC Categories

- In the past the we attempted to match the ATC to the appt type-**now they are completely unrelated**
- Most **important** task when booking is to determine acuity of complaint & then choose an appt type that meets their assigned ATC standard (preferably same day)

Any ATC can be placed into ANY open Appointment

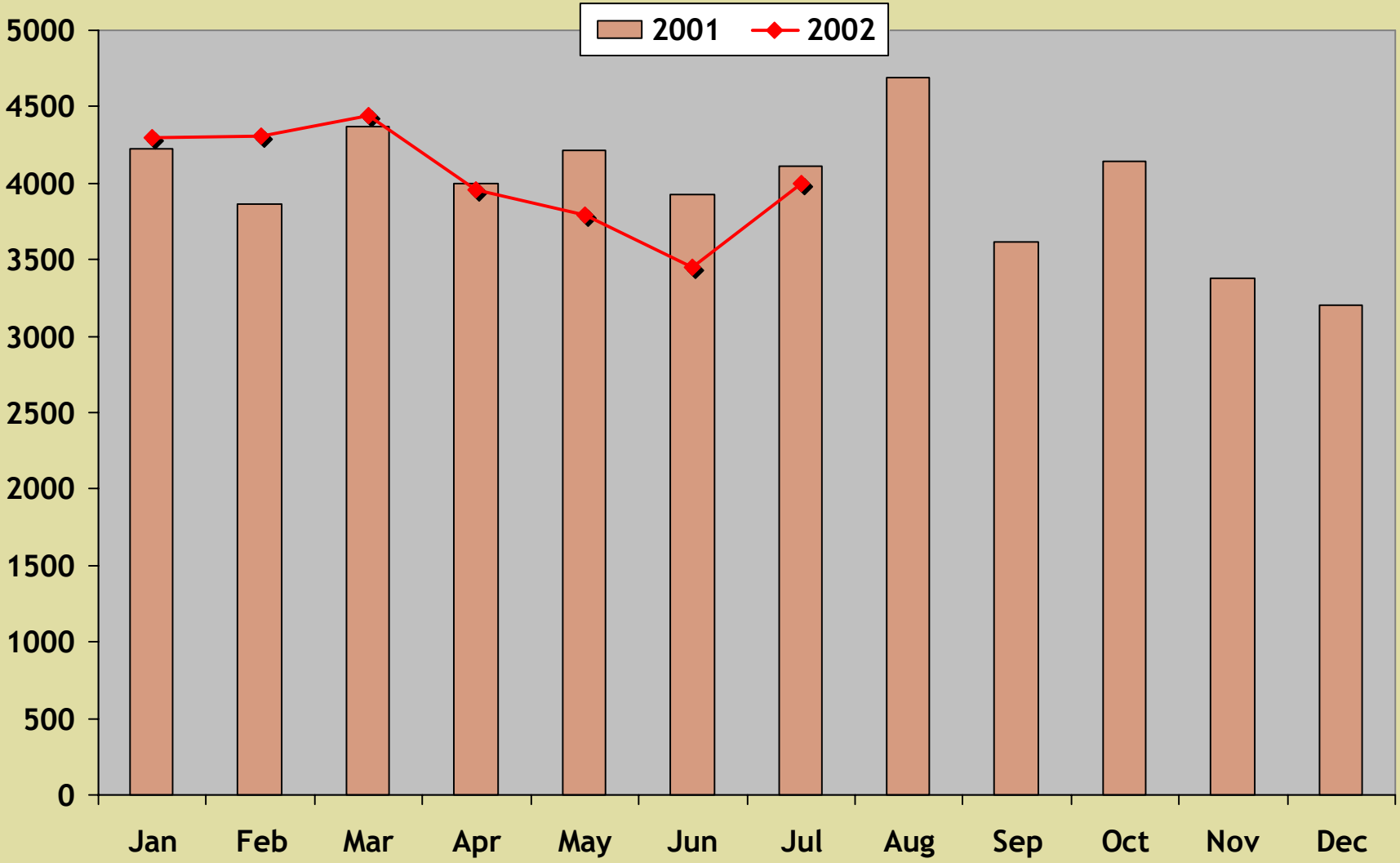
- **Acute:** needs to be seen in 1 day or less to prevent further harm to patient*: Laceration, high fever, painful injury, infection*
- **Routine:** can wait up to 7 days without risk of further harm to patient: Uncomplicated rash, mild fever, etc
- **Wellness:** can wait 30 days without risk of further harm to patient
- **Specialty:** can wait 30 days without risk of further harm to pt: PHAs, PFT, DRCs other “special” appt

Family Practice
All Appointments



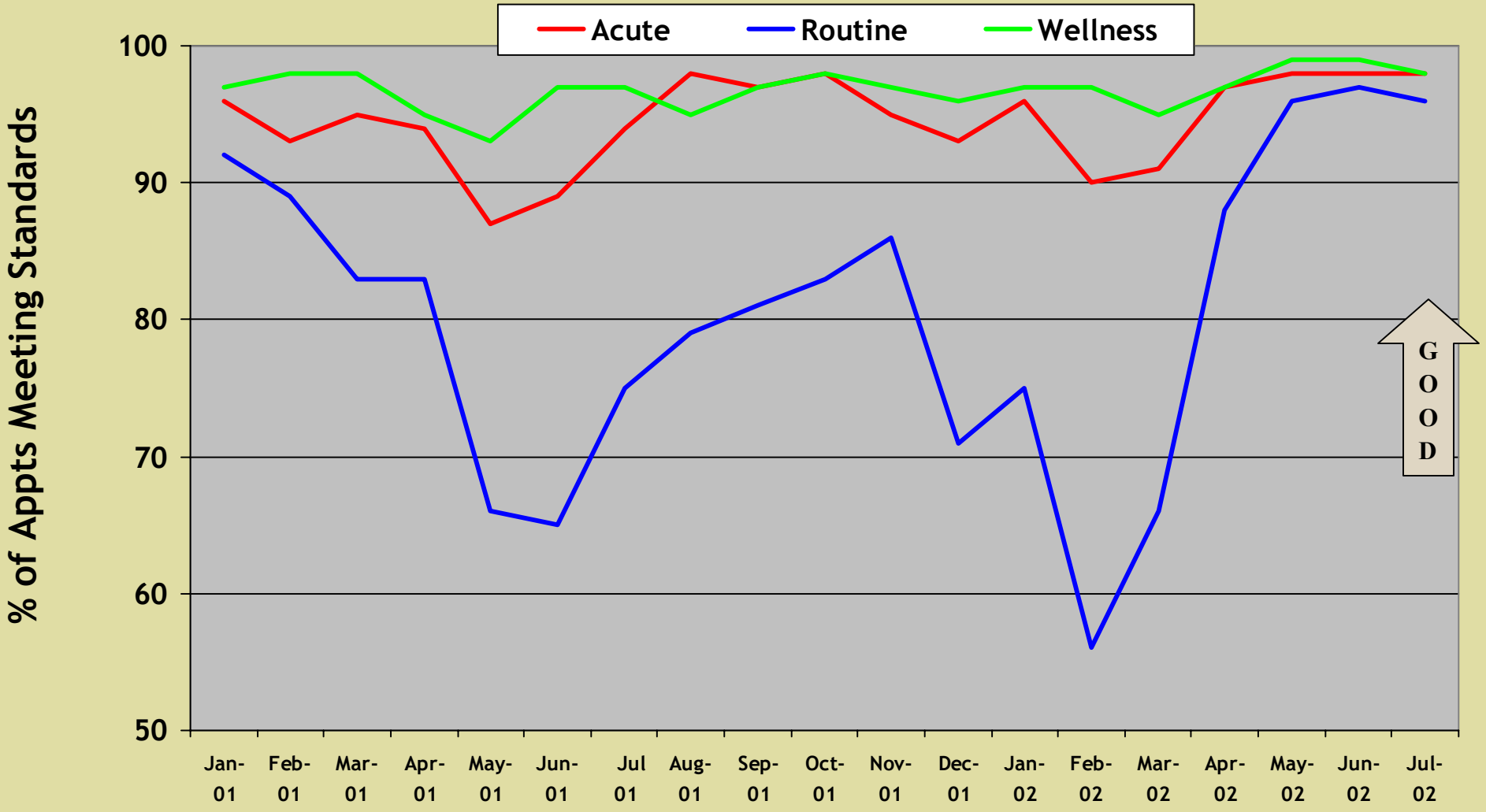
Source: CHCS – Monthly Statistical Report

Family Practice
All Appts + All T-Cons



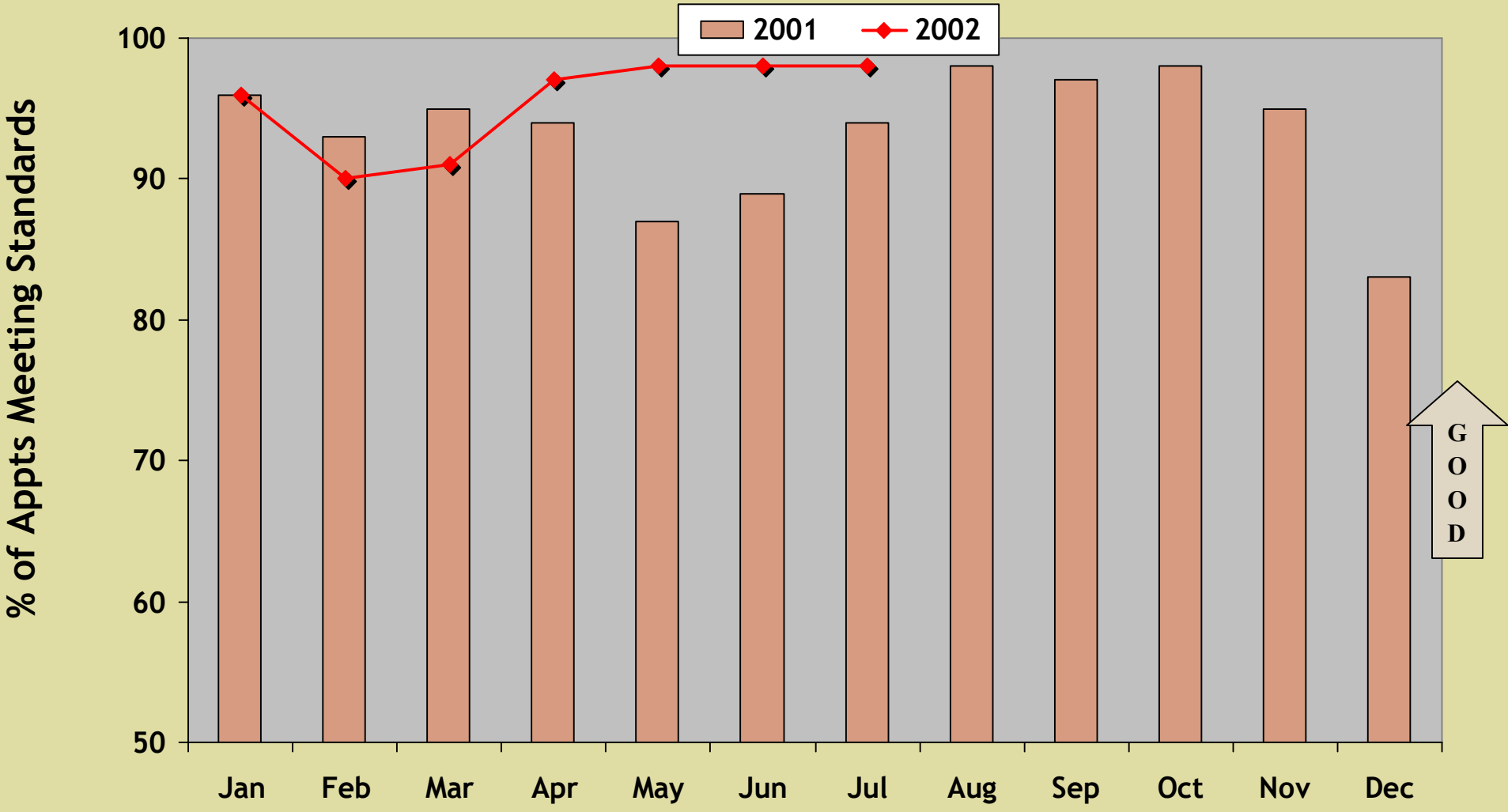
Source: CHCS – Monthly Statistical Report

Access to Care
All Appointments



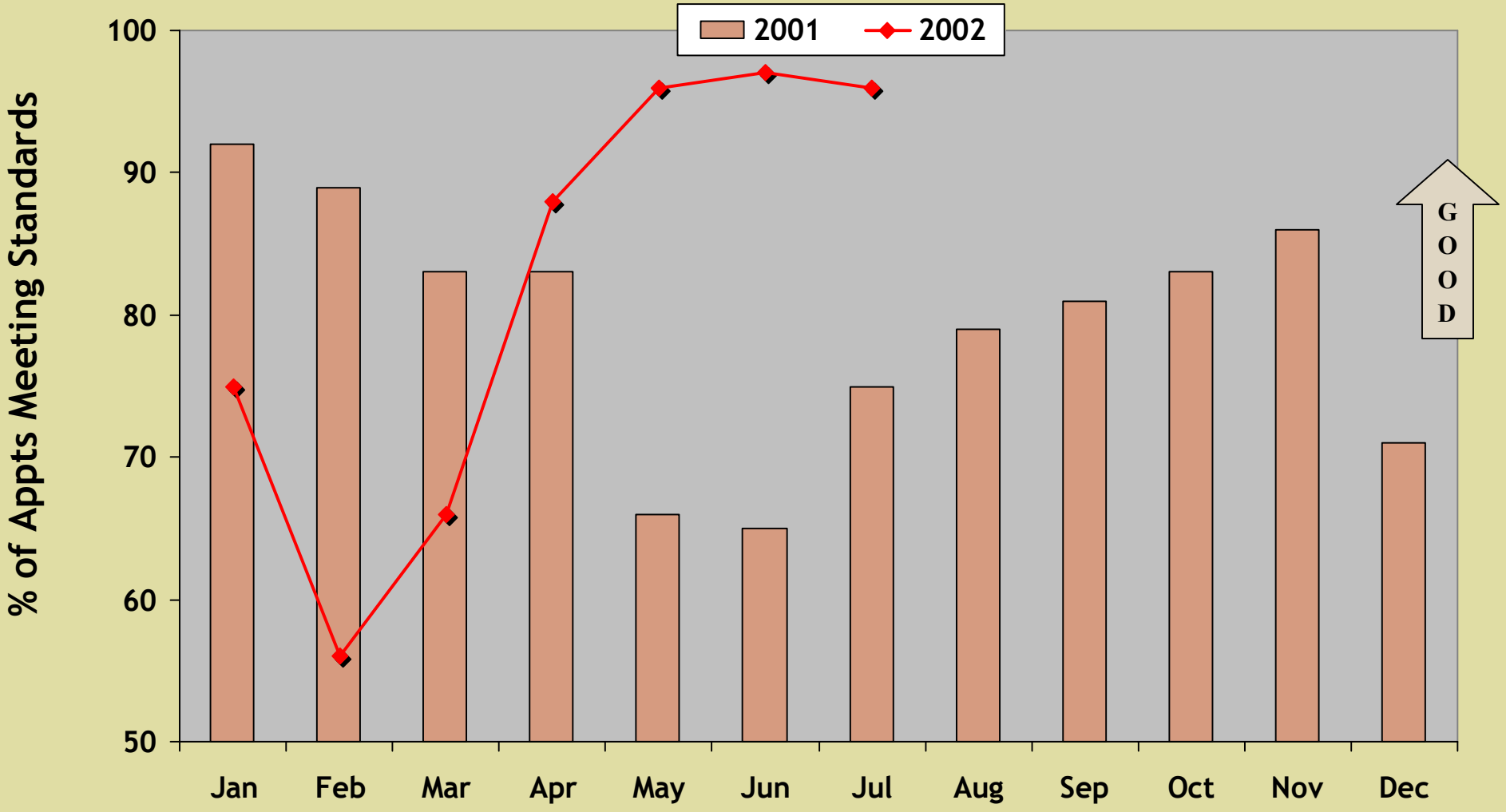
Source: CHCS – Access to Care Report

Access to Care
Acute Appointments



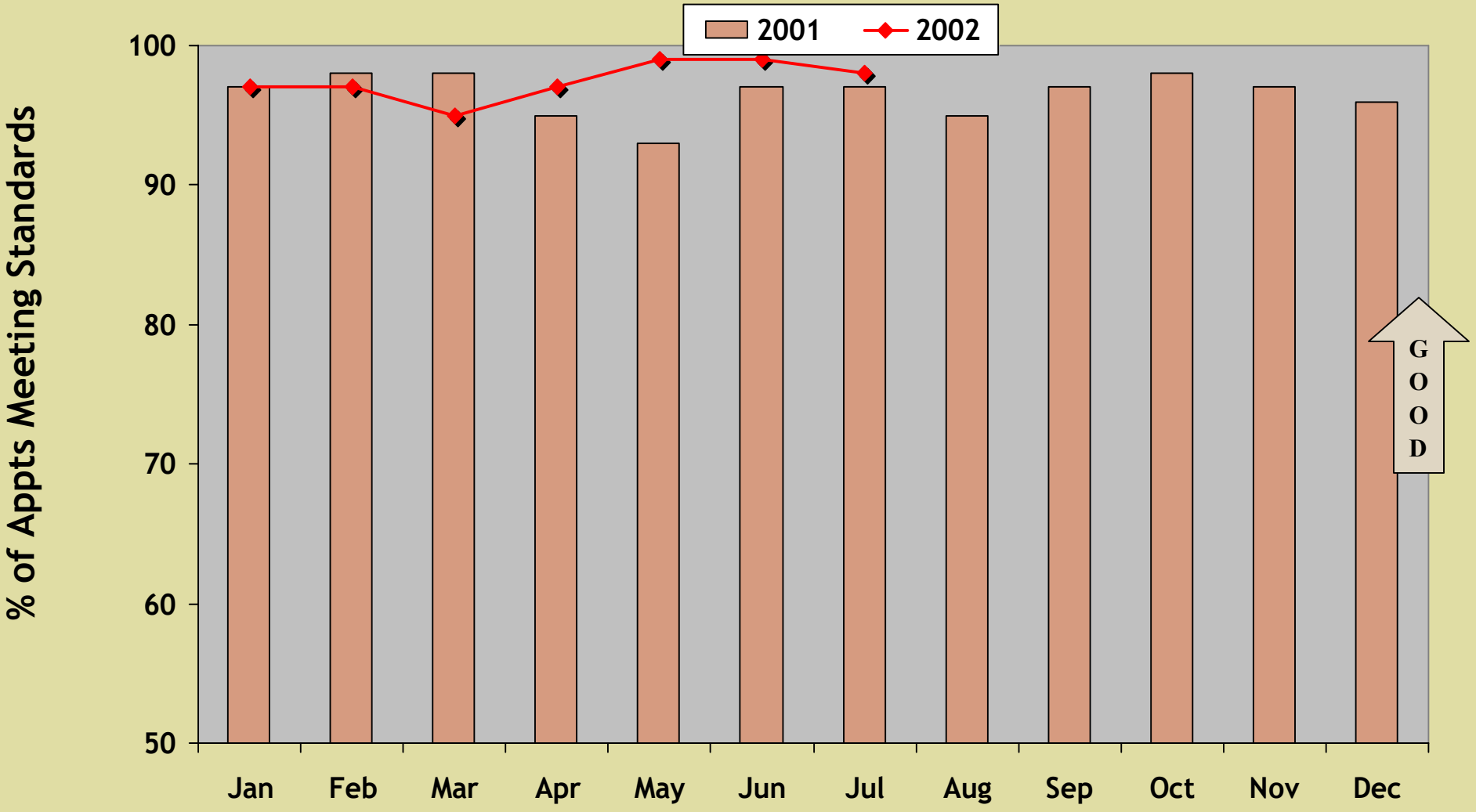
Source: CHCS – Access to Care Report

Access to Care
Routine Appointments



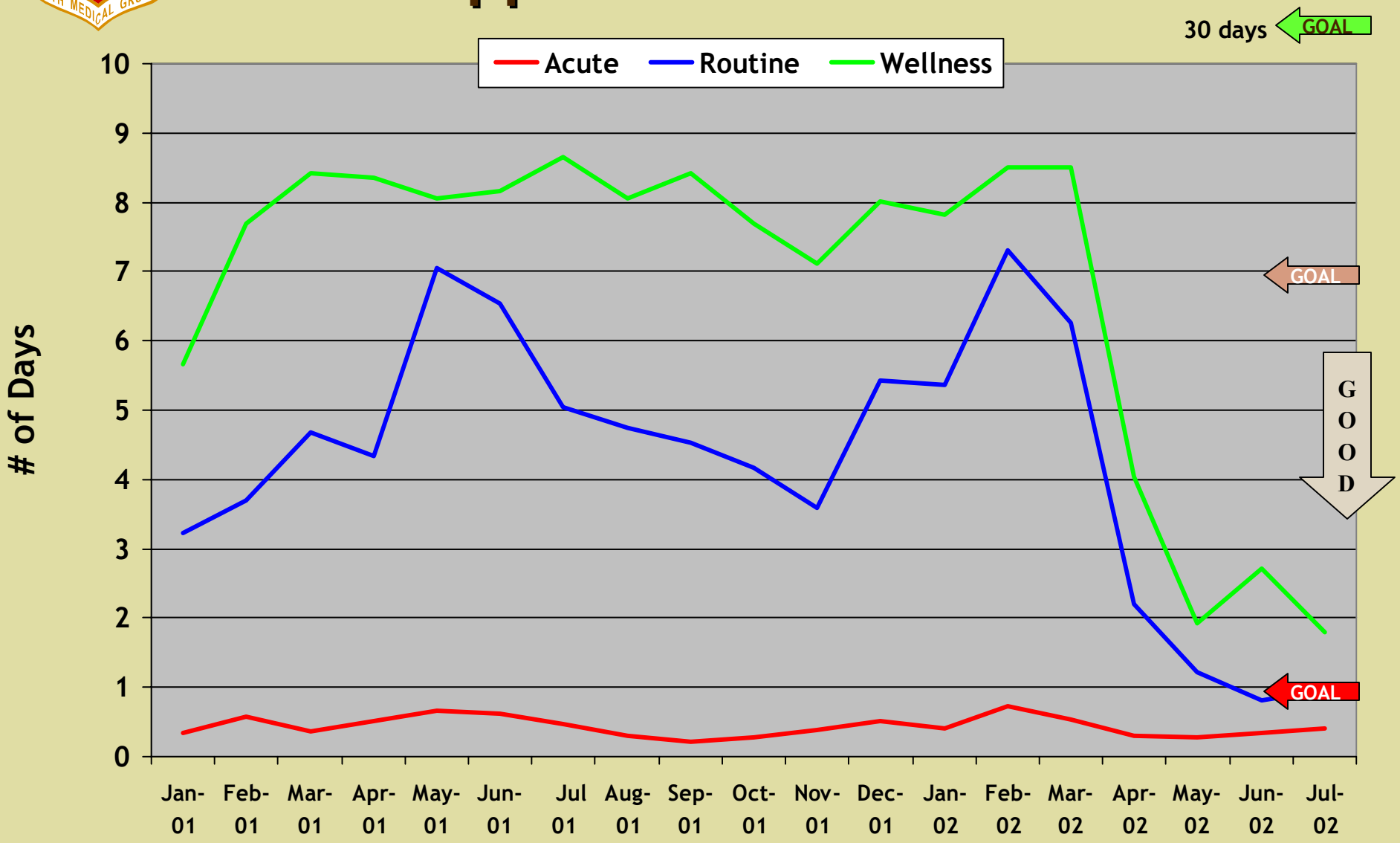
Source: CHCS – Access to Care Report

Access to Care
Wellness Appointments



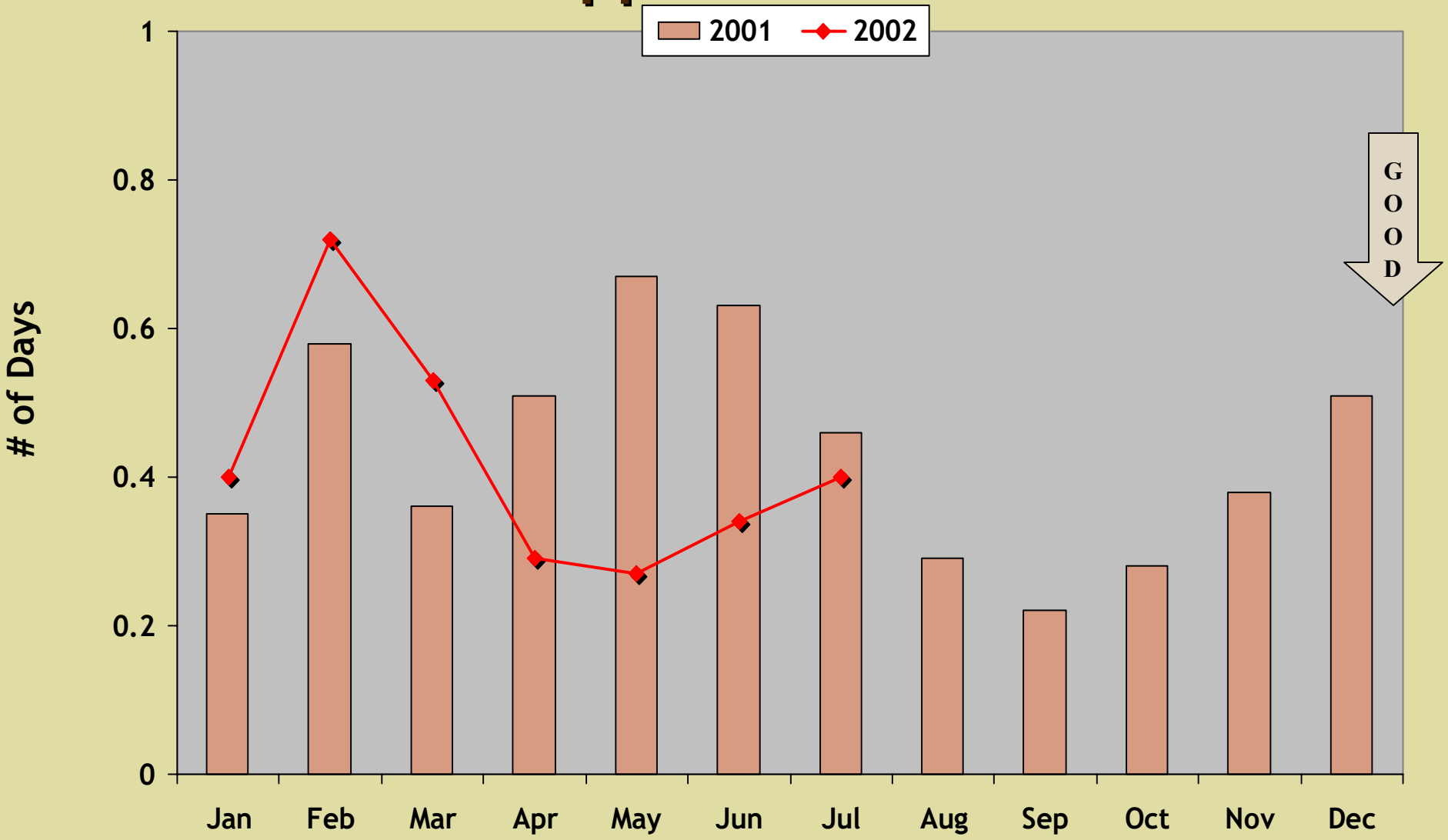
Source: CHCS – Access to Care Report

Average Wait Days
All Appointments



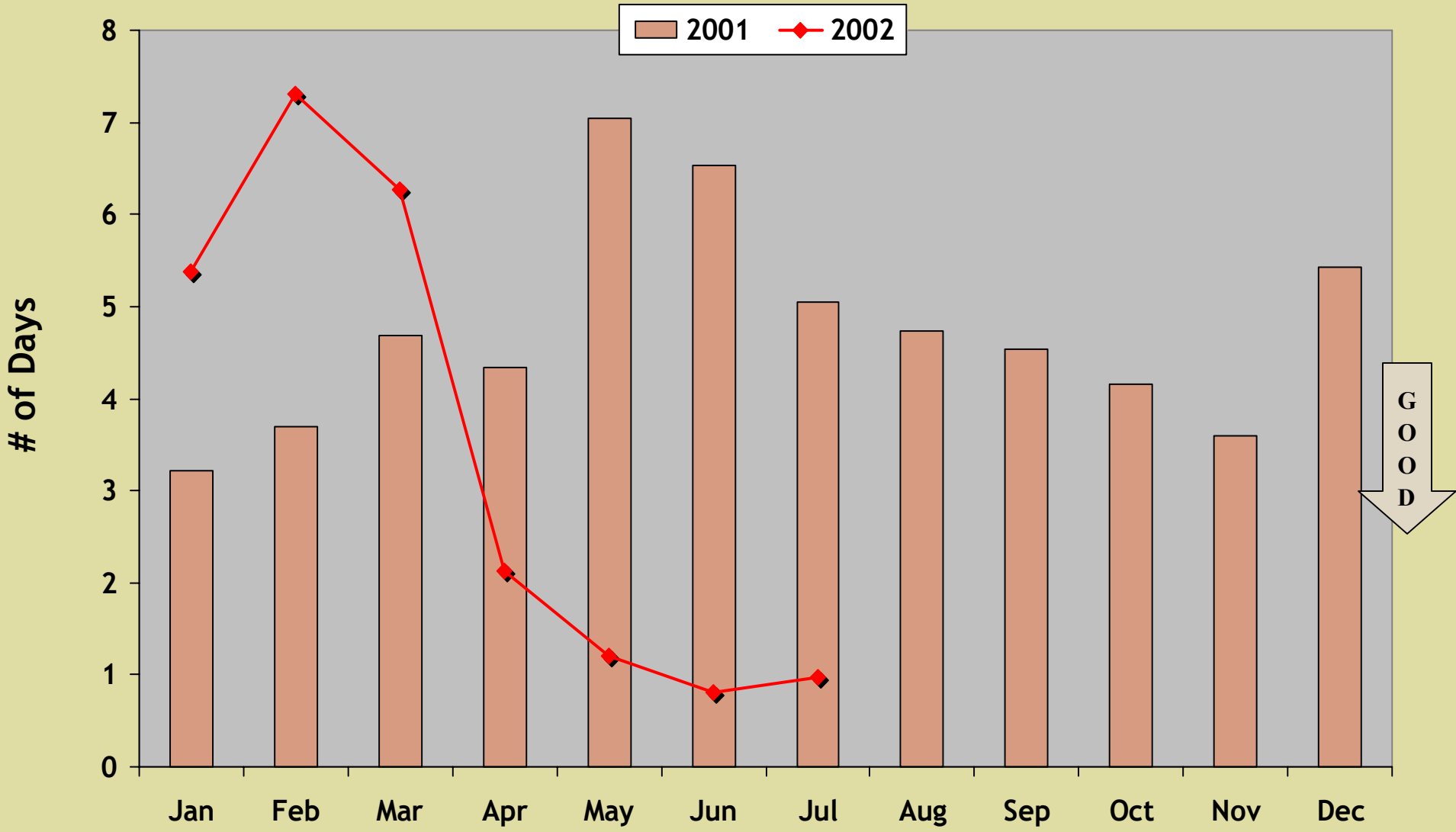
Source: CHCS – Access to Care Report

Average Wait Days
Acute Appointments



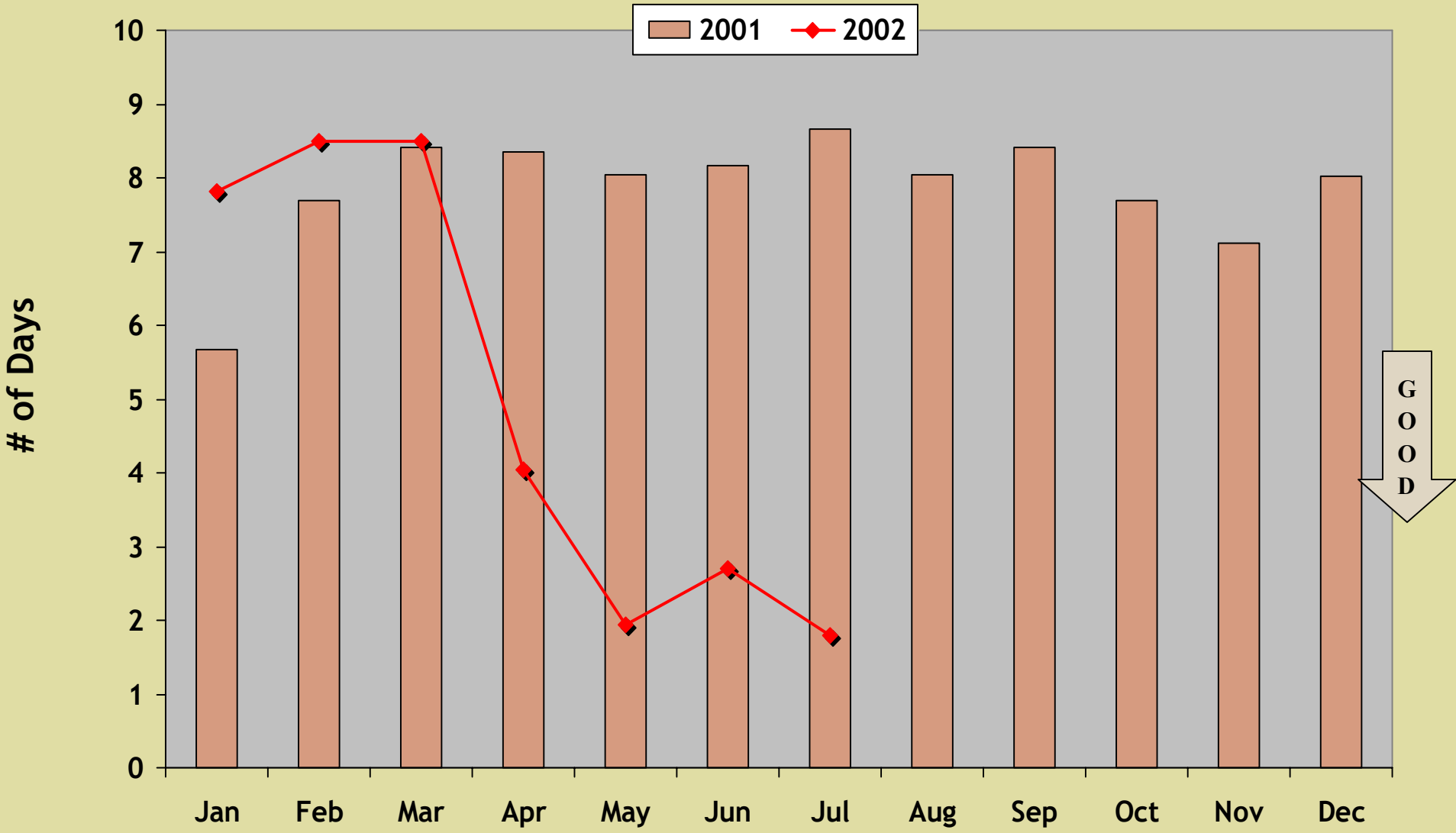
Source: CHCS – Access to Care Report

Average Wait Days
Routine Appointments



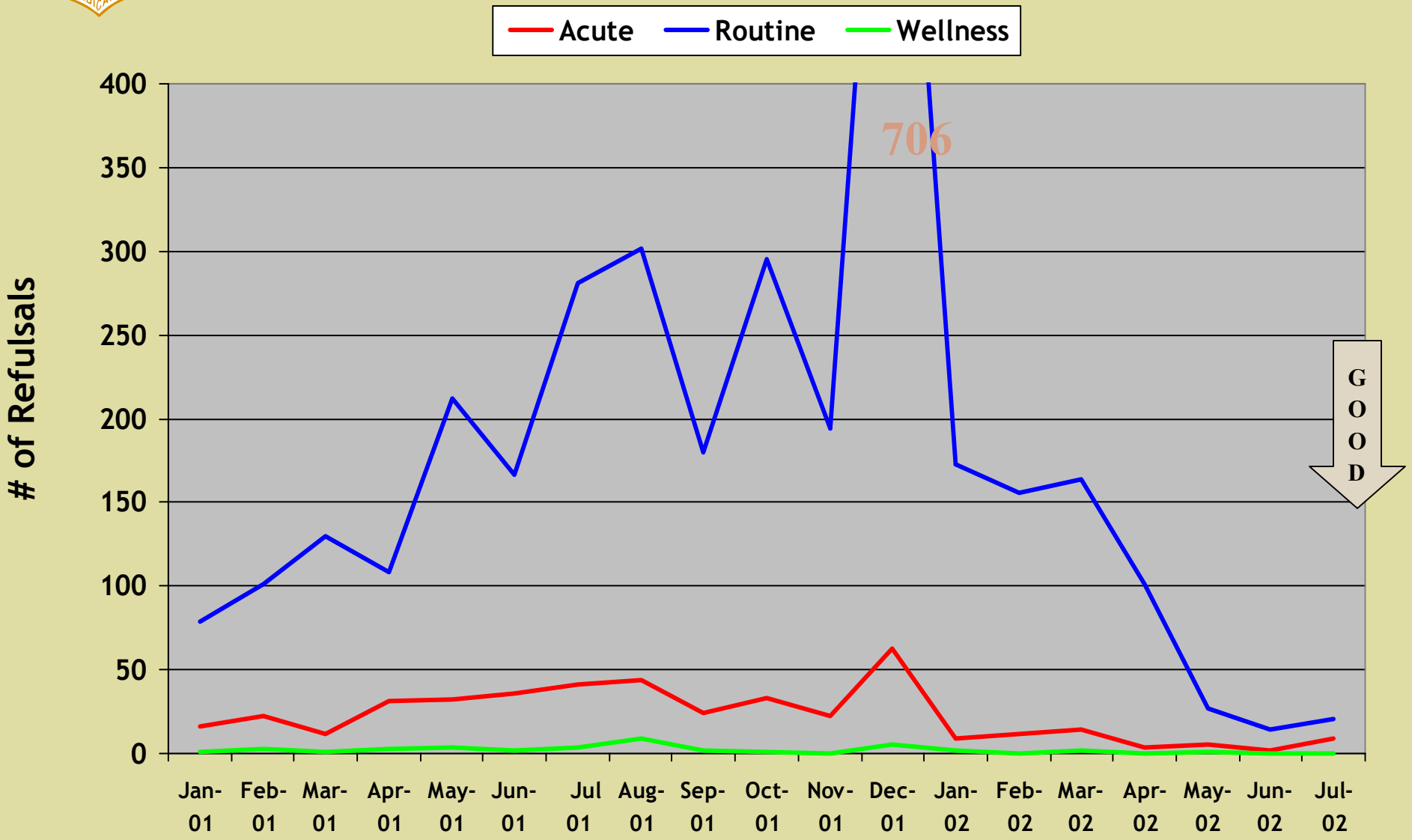
Source: CHCS – Access to Care Report

Average Wait Days
Wellness Appointments



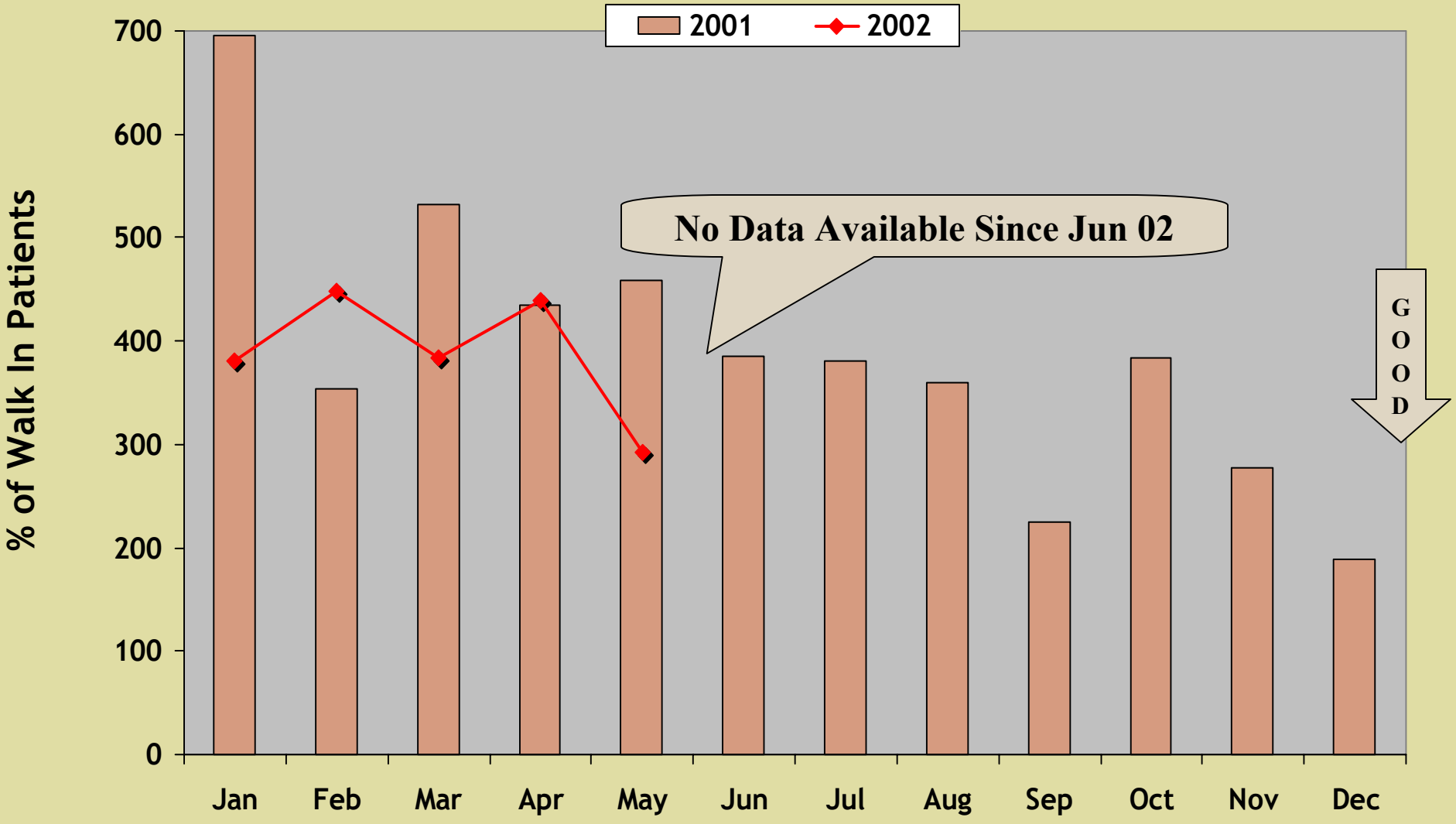
Source: CHCS – Access to Care Report

Appointment Refusals
All Appointments



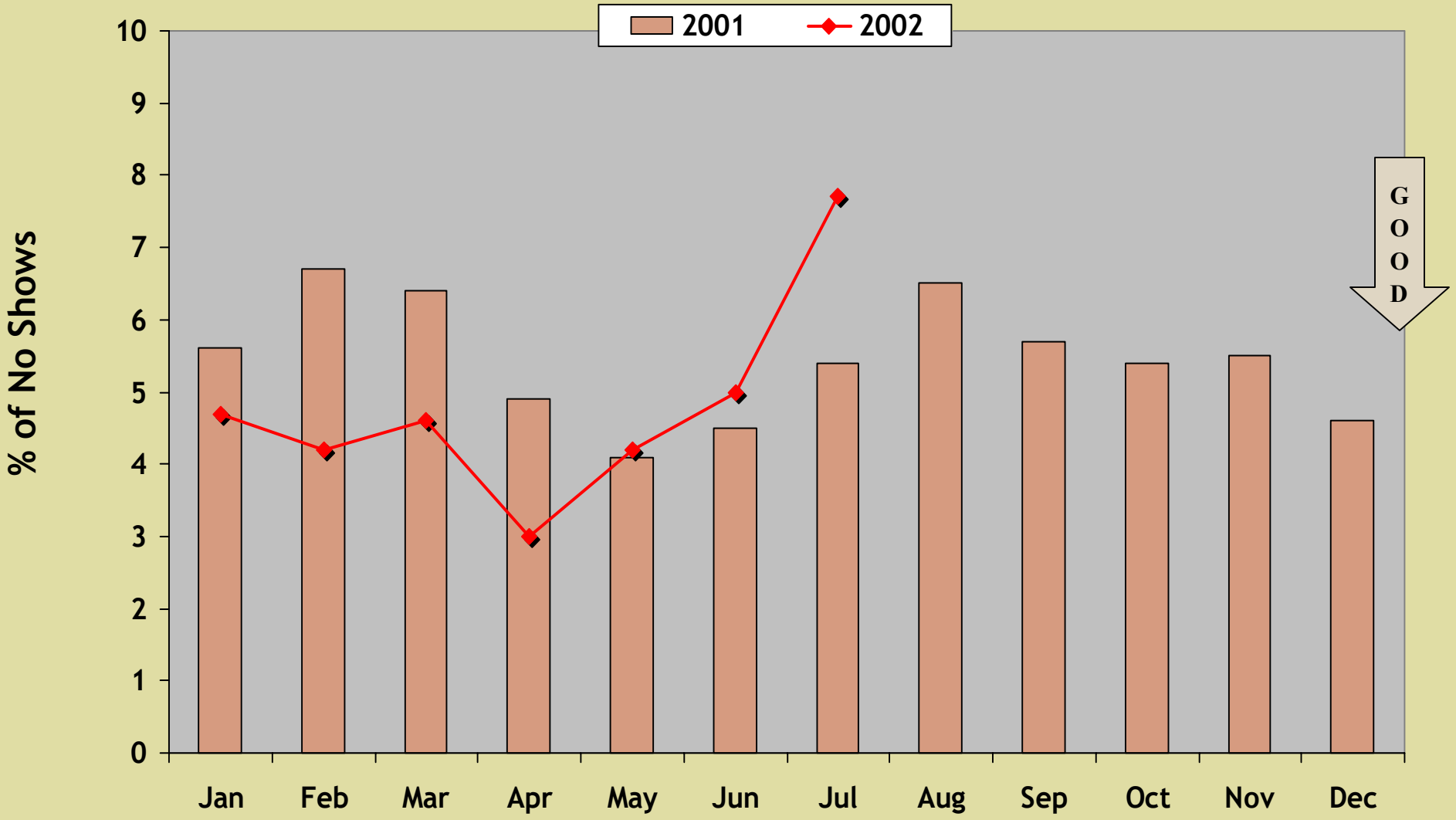
Source: CHCS – Access to Care Report

Walk In Rate



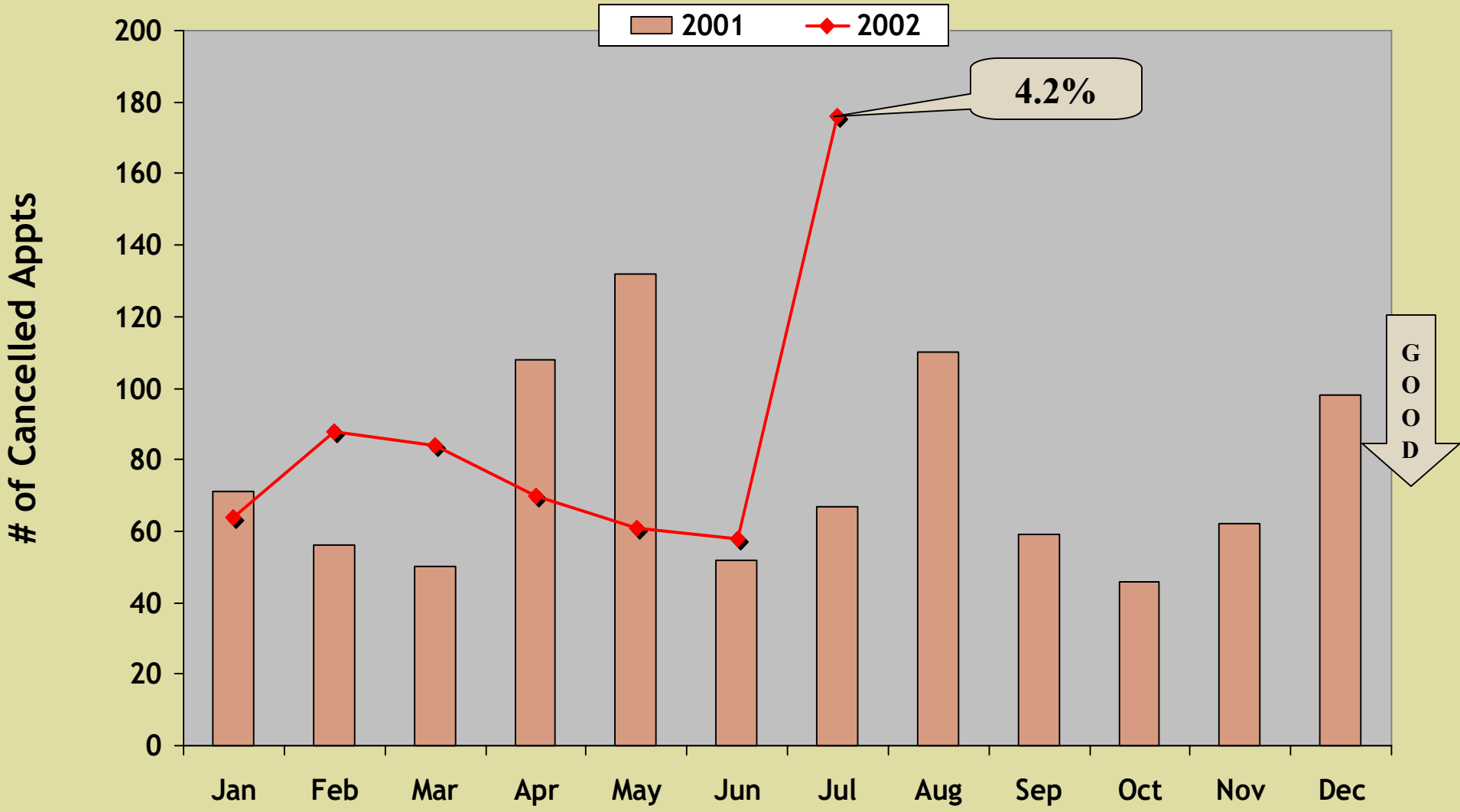
Source: CHCS – ADS Ad Hoc Report

o Show Rate



Source: CHCS – No Show Statistical Report

Appts Cancelled by Facility



Source: CHCS –Facility Cancellation Statistical Report

Lessons Learned

- What about Triage??
  - Definition: Triage is a front-end demand management tool where every request for same-day service is screened for medical necessity and appropriateness
  - Goal: Keep patients out of the office or guide them to other care sites or sources/resources
  - Patient must prove they are sick enough to be seen…harsh?? Maybe….maybe not…read on:
  - Research shows that approximately 30-40% of visits to Primary Care were found to be inappropriate or could have been handled over the telephone

Lessons Learned (Triage)

- When offered rapid access to medical information and advice, 77% chose not to go into the office
- 50-60% of patients choose self-care and 20-25% opt for next day appointment
- Access to care greatly increase for those in need

Source:

Honeycutt and Burke, Journal for Healthcare Information Management Systems Society, 1998. Barr, Laufenberg and Sieckman, Journal for Healthcare Information Management Systems Society, 1998.

Lessons Learned

- Care Extender Protocols
- Training, Training, Training
- Judicial use of all employees, ie IDMTs, non-PCM providers & Nursing staff: Provider absences kill Open Access
- Monitor staffing during & after phase in
- Educate population or not???
- Monitor appts during the day to make certain unused EST, ACUTE, and WELL appts are rolled over to ACUTE

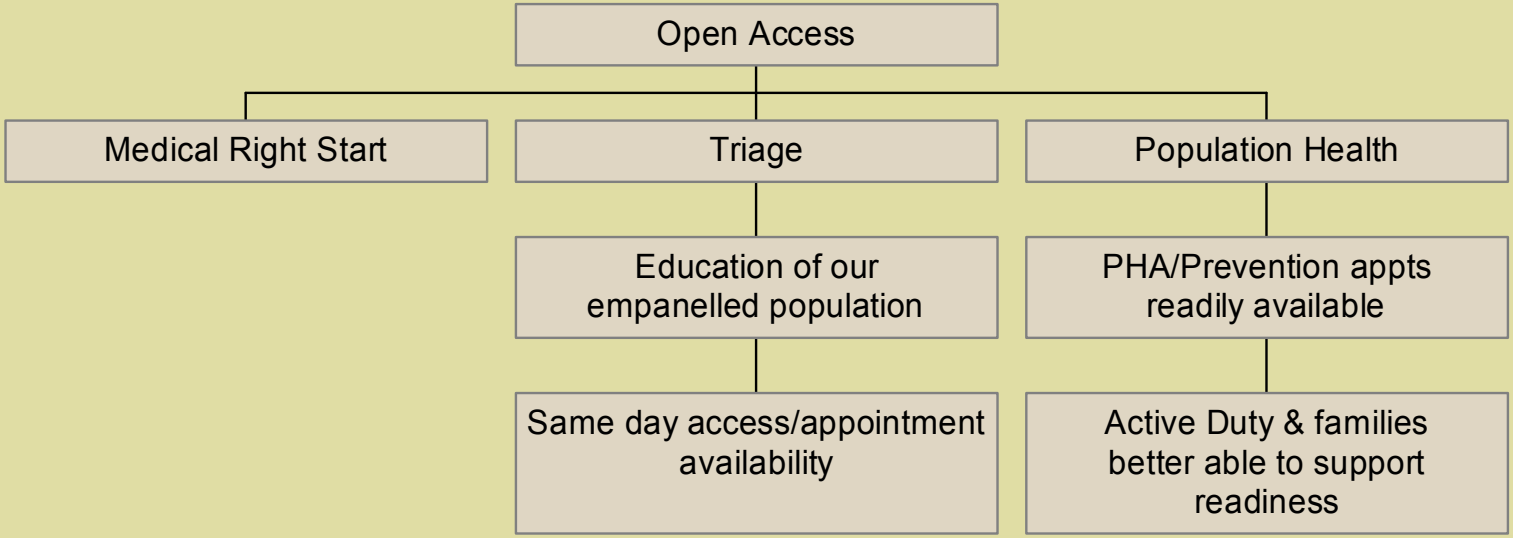
Lessons Learned

- Book provider follow-ups (EST) before patient leaves the clinic…..less confusion.
- Work closely with Central Appts on a daily basis. Correct all discrepancies and brief staff, especially if appt clerks not co-located with clinic (unfamiliar with clinic operations and clinic staff)
- Outpatient Records Retrieval: Much more challenging under OA. Developing a system to pull records the evening before (ambulance crew) and several times during the morning of the day of appointments

Lessons Learned

- PCO needs to be alive and well!! Staffing, care extender protocols, prevention (CPG/metrics, medical right start, Self-care

Bottom Line


Open Access
Medical Right Start
Triage
Population Health
Education of our empanelled population
PHA/Prevention appts readily available
Same day access/appointment availability
Active Duty & families better able to support readiness

SUMMARY

- RIGHT PATIENT
- RIGHT PROVIDER
- RIGHT TIME
- RIGHT PLACE

- Video

Questions ??????

- Remember
  - This is an attempt to make schedules more balanced and flexible; yet more standardized, and operate more efficiently
  - This is a Trial- if it doesn't work we will go back to the drawing board